

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-030205

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 213

STATE FILE NUMBER

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

FILED AUG 20 1962

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Fulton</u> TOWN		Length of stay in lb <u>2 mo.</u>	c. CITY OR TOWN <u>Fulton</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 5</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Hubbard</u> Last <u>Hubbard</u>		4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-3-1899</u>
9. AGE (last birthday) <u>63</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hospital attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Hospital No. 1</u>	
11. BIRTHPLACE (City and state or country) <u>Boone County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John D. Hubbard</u>		13b. MOTHER'S MAIDEN NAME <u>Willie Martin</u>	
14. NAME OF HUSBAND OR WIFE <u>Lillian Hubbard</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. INFORMANT <u>State Hospital No. 1, Fulton, Mo.</u>		17. ADDRESS <u>State Hospital No. 1, Fulton, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>bronchopneumonia</u> DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>cerebral arteriosclerosis; pulmonary tuberculosis - arrested</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>  </u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>State Hospital No. 1</u>		20f. CITY, TOWN, OR LOCATION <u>6-29-1962</u>	
21. He attended the deceased from <u>6-29-1962</u> to <u>8-17-1962</u> Death occurred at <u>9:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Morris Gordon MD</u>	
22b. ADDRESS <u>Fulton, Missouri</u>		22c. DATE SIGNED <u>8/17/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug, 19, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>White Cloud Cem</u>	
23d. LOCATION (City, town, or county) <u>W. Fulton Callaway</u>		(State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Browning Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>Aug-17-1962</u>	
26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

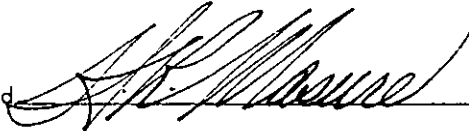
(Licensed Embalmer's Statement on Reverse Side)

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed



Licensed Embalmer No.

4996

P. O. Address

Sutton, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.